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North Carolina

Medicaid Pharmacy

Newsletter

Number 103 ***July 2001***

In This Issue...

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Change in Allowable Days Supply on Prescriptions

Effective July 1, 2001, the maximum days supply for all drugs, except birth control pills, changed from 100 days to a 34-days supply. Up to 100 days supply (3 packs) of birth control pills will still be allowed. If the drug is packaged in an unbreakable package and will last longer than 34 days, then the claim should be filed for that quantity and a 34-days supply should be indicated even though it will last longer. The pharmacist should use his/her best judgement in determining the days supply.

When the edit was changed to allow a maximum of a 34-days supply, we found that some drugs are denying because the dose being given is above the FDA's and the manufacturer's recommended dose. These claims will need to be submitted on a paper claim form with the physician's directions indicated at the bottom of the form. This will assist us in compiling a list of drugs that will require a change in the system for the maximum dosage per day. It is not our intent to continue to have these claims filed on paper, but to assist us in identifying the drugs that need to be adjusted.

Claims filled prior to July 1, 2001 for a days supply greater than 34 days, should be sent in as soon as possible. These claims will need to be sent on a paper claim form with a 34-days supply indicated in the detail and the actual days supply in the space provided at the bottom of the claim form.

Responding to the Early Refill Alert

The overutilization alert warns the pharmacist of early refills and/or potential abuse situations. This alert identifies prescriptions submitted for another supply of the same drug when the patient's medication history shows greater than 25 percent of the previously dispensed days supply remains. Currently if you receive a message that a refill is 4 days early, it is actually 4 days until 75% of the medication is used up. This calculation is totally dependent on the days supply entered on the previous prescription, so an accurate days supply should always be entered. Use caution when overriding this alert. Failure to comply with this requirement could result in recoupment

Quantity Limits Put in Place for Oxycontin

Effective July 1, 2001, Medicaid will pay for a maximum of six tablets per day for all strengths of Oxycontin. Under the new 34-day supply limit, this means that a maximum of 204 tablets per month will be allowed.

Only in extreme cases will exceptions to this limit be approved. The prescriber will be required to submit a request for prior approval accompanied by documentation of medical necessity for this drug. This request must be signed by the prescriber and sent to the following address:

Benny Ridout, R.Ph
Pharmacy Director
Division of Medical Assistance
2511 Mail Service Center
Raleigh, NC 27699-2511
FAX: 919-715-9025

An authorization code will be assigned to all prior authorizations that are approved. This code must be included on the prescription to notify the pharmacist that the prescription has been approved for dispensing. The pharmacist will be required to submit a paper claim form for all prescriptions that exceed the allowable amount and also include the prior approval number on the bottom of the this form.

Generic Substitution

The General Assembly authorizes and mandates pharmacists participating in Medicaid to substitute generic drugs for brand or trade name drugs unless the prescriber specifically orders the brand name drug. A prescription for a drug designated by a brand or trade name for which one or more equivalent drugs are available should be considered to be an order for the drug by its generic name, except when the prescriber personally indicates in his/her own handwriting on the prescription order, "Brand Medically Necessary".

The selection of a drug product shall not be more expensive than the brand or trade name originally written for by the prescriber. The pharmacist shall fill the prescription with the least expensive generic in the pharmacy, unless a specific brand or trade name is specified by the prescriber in the required manner. For audit purposes, the brand name and manufacturer must be documented on the prescription.

Billing Procedures for Compounds

Compounds that contain only legend drugs can be billed using the new method of billing as illustrated in the June and November 2000 newsletters. This billing method can now be used with the ECS software, as well on paper. If the compound contains OTC's, the old method should be used and is described in detail in the pharmacy manual on page 17.

The dispensing fee should be included with each line item and the system will decide which drug it will pay the dispensing fee on. The Remittance Advice will show the first drug paid with the dispensing fee and the subsequent drugs in the compound or a refill of the same compound will have EOB 1545 –Additional Compound Ingredient or Repeat Medication, Professional Fee Previously Paid.

Examples can be found in the June 26, 2000 and November 1, 2000 Newsletters. Please be aware that the examples in the June Newsletter did not include a dispensing fee with each line item, but this should be included. For specific questions regarding compound billing, contact Dora De Van at (919) 816-3056.

Changes in Drug Rebate Manufacturers

The following changes are being made in manufacturers with Drug Rebate agreements. They are listed by Manufacturer code, the first five digits of the NDC.

Additions
The following labelers have entered into drug rebate agreements and joined the rebate program effective on the dates indicated below:

Code	*Manufacturer*	*Date*
55402	Pharmakon Labs, Inc.	5/8/2001
64108	Optics Laboratory Inc.	5/24/2001
66073	Healz-Plus, Inc.	5/21/2001

Information on the Health Insurance Portability and Accountability Act

What is HIPAA?

In response to the growing need for health care reform and cost reductions, on August 21, 1996, Congress enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA's Administrative Simplification provisions address the need for consistency throughout the health care industry and require the U.S. Department of Health and Human Resources to establish national standards for electronic data exchange while protecting the security and privacy of health care information.

While electronic health care transactions can be a more efficient way to process claims and payment information, providers are faced with many different health plans, each of which may have different coding and data content requirements. HIPAA will improve administrative efficiency and reduce operating costs for all health care providers by standardizing the data elements, code sets, and identifiers used throughout the health care industry.

The federal regulation introducing electronic health transaction standards became effective on October 16, 2000. These standards apply to:

- Eligibility information
- Health care claims
- Health care claim attachments
- Health care payments and remittance advices
- Health plan premium payments
- Referral authorizations
- Coordination of benefits
- First report of injury

The use of electronic technology to transmit health information has also created a need to address security and privacy issues. HIPAA seeks to protect the confidentiality of individual medical information by addressing privacy standards not only for electronic transactions but for verbal and paper exchanges as well.

The federal regulation establishing standards for the privacy of individually identifiable health information became effective on April 14, 2001. The regulation establishes accountability and responsibility for the disclosure of health information where the information is used to protect public health, to conduct medical research, and to improve the quality of consumer health care. Any health information that can be used to identify a person is covered by this regulation.

Who Must Comply with HIPAA?

All health plan providers, payers, and clearinghouses that process health data **electronically** must comply with the national standards for electronic data transactions by October 16, 2002. Business associates who are contracted to perform a function on behalf of these entities must also comply with HIPAA regulations. Small health plans – those with less than $5 million in annual receipts – have an additional 12 months to comply with the regulation.

HIPAA also requires health care plans, providers, clearinghouses, and contracted business associates to implement the provisions of the privacy regulation by April 13, 2003. Small plan providers have an additional 12 months to comply with the regulation.

What is the N.C. Medicaid Program Doing to Comply with HIPAA?

The N.C. Medicaid program is committed to implementing HIPAA regulations in a timely manner without disruption to the day-to-day business of providers enrolled with Medicaid or to the delivery of services to the citizens of North Carolina. Medicaid providers, as well as recipients, will benefit from the Division of Medical Assistance's enhanced ability to monitor utilization, costs, fraud, and the coordination of care.

As part of the process to implement HIPAA standards, the Division of Medical Assistance (DMA) is evaluating and will convert state-created codes to the standard national data sets listed below. Providers will be alerted to code conversions through articles in the monthly Medicaid bulletin.

Diagnosis codes – *International Classification of Disease, Ninth Edition, Clinical Modification* (ICD-9-CM)
Medical procedure codes – *Health Care Procedural Coding System (HCPCS) and Current Procedural Terminology, Fourth Edition* (CPT-4)
Dental codes – *Current Dental Terminology* (CDT-3)
Drug codes – *National Drug Codes* (NDC)

DMA staff have also completed an assessment of HIPAA's impact to the business units within DMA, and are working on the business and technical design in order to move forward with a plan to implement HIPAA standards. Once the conversion has been completed, DMA will be capable of receiving, processing, and sending standard transactions in accordance with HIPAA standards.

What Should Providers Do to Ensure HIPAA Compliance?
Providers are urged to begin evaluating their billing systems and privacy policies to ensure that they are in compliance with HIPAA for electronic transaction standards and privacy regulations by the implementation deadline dates of October 16, 2002 and April 13, 2003, respectively. Providers may want to begin or expand their use of electronic data interchange (EDI) as part of the evaluation process. The following guidelines will help providers begin the process of HIPAA implementation.

Education – Determine what type of training your staff need to facilitate changes to your business practices.

Privacy and Security – Designate a privacy officer for your organization.

Documentation – Evaluate and document policies and procedures related to the protection of health care information within your organization, including procedures for disaster recovery, facility security, workstation security, and access controls. Develop a notice of information practice.

Individual Rights – Allow individuals to inspect, copy, correct, and amend their protected health information.

Disclosure – Implement measures to account for disclosure of information for purposes other than treatment, payment or health care administration.

Business Systems – Evaluate your billing system for compliance.

Electronic Data Interchange (EDI) – Evaluate the benefits of using or expanding the use of EDI for business transactions

How to Get More Information

Additional information on HIPAA regulations, transaction standards, and privacy and security issues can be found on the Health Care Financing Administration (HCFA) website at www.hcfa.gov or the U.S. Department of Health and Human Service's website at www.aspe.os.dhhs.gov/admnsimp/.

Information on EDI vendors can be obtained from the Electronic Commerce Unit at EDS by calling 1-800-688-6696 or 919-851-8888.

Tom Lambert, HIPAA Coordinator
DMA, 919-857-4013
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MAC List Changes

Effective June 14, 2001, the following changes occurred to the Medicaid Drug Federal Upper Limit List:

Deletions

Generic Name

Haloperidol
.5 mg, Tablet, Oral, 100
1 mg, Tablet, Oral, 100
2 mg, Tablet, Oral, 100
5 mg, Tablet, Oral, 100

Prednisolone Sodium Phosphate
EQ 1% Phosphate, Solution/Drops, Ophthalmic, 5 ml

Theophylline
450 mg, Tablet, Extended Release, Oral, 100

Price Changes

Generic Name	Price
Acetaminophen; Codeine Phosphate	
300 mg; 15 mg, Tablet, Oral, 100	$0.1124
300 mg; 30 mg, Tablet, Oral, 100	$0.2137
300 mg; 60 mg, Tablet, Oral, 100	$0.2812
Acetaminophen; Hydrocodone Bitartrate	
500 mg; 7.5 mg, Tablet, Oral, 100	$0.2340
Amitriptyline Hydrochloride	
50 mg, Tablet, Oral, 100	$0.0666
Diflunisal	
500 mg, Tablet, Oral, 60	$0.5135
Dipyridamole	
75 mg, Tablet, Oral, 100	$0.1359
Gramicidin; Neomycin Sulfate; Polymyxin B Sulfate	
0.025 mg/ml; EQ 1.75 mg base/ml; 10,000 units/ml, Solution/Drops, Ophthalmic, 10 ml	$2.2185
Metoclopramide	
10 mg, Tablet, Oral, 100	$0.1095

Generic Name	**Price**
Prazosin Hydrochloride	
EQ 1 mg Base, Capsule, Oral, 100	$0.1335
EQ 2 mg Base, Capsule, Oral, 100	$0.2692
EQ 5 mg Base, Capsule, Oral, 100	$0.4328
Theophylline	
200 mg, Tablet, Extended Release, Oral, 100	$0.1284
300 mg, Tablet, Extended Release, Oral, 100	$0.1313
Verapamil Hydrochloride	
240 mg, Tablet, Extended Release, Oral, 100	$0.3593

DESI Additions

NDC	**Product Name**	**Manufacturer**
00115-7012-03	Aminobenzoate Potassium	Global Pharmaceutical Corp.
00405-4575-03	Isoxsuprine HCL 10mg	Aligen Independent Laboratories
00405-4576-03	Isoxsuprine HCl 20mg	Aligen Independent Laboratories
00405-4794-01	Phenobarb/Ergo Tart/Bella	Aligen Independent Laboratories
00677-1125-03	Isomethep/Dichlor/APAP	United Research Laboratories
00677-1745-01	Isomethep/Dichlor/APAP	United Research Laboratories
52152-0115-05	Bellamine S Tablets	Amide Pharmaceutical Inc.

Checkwrite Schedule

July 10, 2001	August 7, 2001	September 5, 2001
July 17, 2001	August 14, 2001	September 11, 2001
July 26, 2001	August 23, 2001	September 18, 2001
		September 27, 2001

Electronic Cut-Off Schedule

July 6, 2001	August 3, 2001	August 31, 2001
July 13, 2001	August 10, 2001	September 7, 2001
July 20, 2001	August 17, 2001	September 14, 2001
		September 21, 2001

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date.

Paul R. Perruzzi, Director
Division of Medical Assistance
Department of Health and Human Services

Ricky Pope
Executive Director
EDS

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Raleigh, North Carolina 27622

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